NEVADA STATE BOARD OF MEDICAL EXAMINERS
APPLICATION FOR PRACTITIONER OF RESPIRATORY CARE LICENSURE
FEE SCHEDULE FOR FEBRUARY 28, 2007 THROUGH FEBRUARY 29, 2008

APPLICATIONS FOR PRACTITIONER OF RESPIRATORY CARE LICENSURE WILL NOT BE PROCESSED WITHOUT RECEIPT OF BOTH THE APPLICATION AND REGISTRATION FEES IN THE FORM OF EITHER A **CASHIER'S CHECK OR MONEY ORDER ONLY**. ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. **Any applications which appear *to have been altered in any form will not be accepted. Applications must be received on single sided white bond paper, 8 ½" x 11" in size.***

Non-Refundable Application Fee----------$100
Active Licensure Biennial Registration Fee----------$100
Total---------$200

PLEASE NOTE:

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180 (3). The application fee will not be refunded.

Per Nevada Revised Statute 630.175, "an applicant for a license or a licensee shall report to the board within 30 days any fact which would render any statement to the board by the applicant or licensee false, misleading, inaccurate or incomplete."

The Nevada State Board of Medical Examiners conducts an investigation into your background and if, in the process, staff becomes aware of circumstances warranting a personal appearance before the board at a board meeting, your application must be completed 45 days prior to any regularly scheduled board meeting in order for your licensure application to be placed on the agenda of that meeting. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held. If, at the time you meet with the board, the board votes to **not** accept your application for licensure, this non-acceptance of your application becomes a reportable action to the National Board for Respiratory Care, Inc., or its successor organization.

If the practitioner of respiratory care applicant has not practiced as a practitioner of respiratory care for 12 months or more before applying for licensure in this state, he or she may, at the order of the board, be required to take and pass such examination to test professional competency as the board shall deem appropriate.

The practitioner of respiratory care applicant must be able to communicate adequately, both orally and in writing, in the English language. The practitioner of respiratory care applicant must be of good moral character and reputation. If a licensee loses certification by the National Board of Respiratory Care, Inc., or its successor organization, his or her license to practice respiratory care in Nevada is automatically suspended until further order of the board. The practitioner of respiratory care shall immediately notify the board of termination of employment as a practitioner of respiratory care. The practitioner of respiratory care shall submit to the board a summary of the reasons for and circumstances of the termination of employment.

Practitioner of respiratory care licenses will be issued in the applicant's name as indicated on the submitted documentation for proof of such name (i.e. U.S. birth certificate, Certificate of Naturalization or alien registration card).

Grounds for rejection of an application for practitioner of respiratory care licensure:

If it appears that:

1. An applicant for licensure as a practitioner of respiratory care is not qualified or is not of good moral character or reputation;
2. Any credential submitted is false; or
3. The application is not made in proper form or other deficiencies appear in it, the application may be rejected.

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT:

_____a. Properly completed, signed and notarized application, pages 1 – 3;

_____b. Recent photograph of applicant (at least 2" x 2") attached to page 3 of application, signed by applicant in ink on lower edge of photograph;

_____c. Appropriate explanations attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 13, 19, 20, 21, 22, 23 and 24. Please include copies of court documentation;

_____d. U.S. citizens – Certified copy of birth certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable);

_____e. Foreign-born citizens - Original Certificate of Naturalization or current U.S. passport

_____f. Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;

_____g. Release Form A, signed by applicant and notarized;

_____h. Copy of high school diploma (or general equivalency diploma) or high school transcript indicating graduation date;

_____i. Application and registration fees **payable by cashier's check or money order only**.

TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN TO BOARD OFFICE:
(Verifying agencies may charge a fee.)

_____a. Current certification by the National Board for Respiratory Care, Inc. (Form 1) forwarded directly to the Nevada State Board of Medical Examiners by the National Board for Respiratory Care, Inc., or its successor organization;

_____b. Practitioner of Respiratory Care Education Verification (Form 2);

_____c. State Certification/Registration Verification (Form 3) from all states where applicant is currently licensed or has ever been licensed.

PRACTITIONER OF RESPIRATORY CARE
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Date Received by Board

License No._____

File No._____

(For Board Use Only)

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

2. Business and/or Mailing Address _____
Street City County State Zip

3. Home Address _____
Street City County State Zip

4. Telephone Number _(_____)_____ _(_____)_____ Fax Number _(_____)_____
Office Home

5. Date of Birth _____ Place of Birth _____

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____

Submit a certified copy of birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of the document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

The "practice of respiratory care" includes:

1. **Therapeutic and diagnostic use of medical gases, humidity and aerosols and the maintenance of associated apparatus;**
2. **The administration of drugs and medications to the cardiopulmonary system;**
3. **The provision of ventilatory assistance and control;**
4. **Postural drainage and percussion, breathing exercises and other respiratory rehabilitation procedures;**
5. **Cardiopulmonary resuscitation and maintenance of natural airways and the insertion and maintenance of artificial airways;**
6. **Carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practitioner**
7. **of nursing relating to respiratory care;**
8. **Techniques for testing to assist in diagnosis, monitoring, treatment and research related to respiratory care, including the**
9. **measurement of ventilatory volumes, pressures and flows, collection of blood and other specimens, testing of pulmonary functions**
10. **and hemodynamic and other related physiological monitoring of the cardiopulmonary system; and**
11. **Training relating to the practice of respiratory care.**

For the purposes of the following questions, these phrases or words have these meanings:

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE ATTACHED SHEET.

8. Do you have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety? _____Yes _____No

9. If you have a medical condition, which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

10. If you use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety? _____Yes _____No _____N/A

11. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____Yes _____No

12. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including U.S. Military), state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, court-martial, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not considered a minor traffic offense) or for any offense which is related to the** to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes _____No

13. Have you previously applied for an allied health license in Nevada? _____Yes _____No

List in **chronological order** all professional education and experience including high school, college, and/or university and military training. Include all periods of time from the date of graduation from high school to the present, whether or not engaged in activities related to medical service. PLEASE SHOW MONTH AND YEAR.

14. List all schools attended (including high school), dates of attendance, and dates of graduation:
*(SUBMIT COPY OF HIGH SCHOOL TRANSCRIPT OR COPY OF HIGH SCHOOL DIPLOMA, **ONLY**. NO OTHER TRANSCRIPTS ARE REQUIRED.)*

School Name	City/State	Place Where Instruction Received	Type of Degree Received	Dates of Attendance From (mo/yr)	To (mo/yr)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

15. Respiratory Degree granted by:

Respiratory School	City / State	Exact Date of Issuance

16. List all activities and places of residence since graduation from respiratory school: (ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.)

City / State / Country	Activity	From (mo/yr)	To (mo/yr)

(All information must begin on the application. If more space is needed, please attach separate sheet)

17. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a respiratory therapist in any state, territory or country.

State/Territory	License #	Date of Issuance	Dates of Practice From (Mo/Yr)	To (Mo/Yr)

18. Are you currently certified by and/or registered with the National Board of Respiratory Care? _____Yes _____No

If "Yes:" Certification/Registration number: _____ Expiration Date: _____
(For those who are certified after 7/1/2002)

If "No", Date scheduled to sit for the exam: _____

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE ATTACHED SHEET.

19. Have you ever been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? _____Yes _____No

20. Have you ever had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

21. Have you ever voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? _____Yes _____No

22. Have you ever failed the National Board of Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration as a practitioner of respiratory care? _____Yes _____No

23. Have you ever had your registration/certification revoked, suspended and/or limited by the National Board of Respiratory Care? _____Yes _____No

24. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

I, _____ being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

_____ _____
Signature of Applicant Date

Subscribed and sworn to before me this _____ day of

_____ , 2_____. Notary

(NOTARY SEAL) Public for the State of _____

My Commission Expires: _____

Residing at: _____

_____

Signature of Notary: _____

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIXTY (60) DAYS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

PROOF PHOTOS, NEGATIVES AND DIGITAL PHOTOS ARE NOT ACCEPTABLE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of myself taken Within the last sixty (60) days.

_____ _____
Signature of Applicant Date

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing board any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical and physical and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

NOTARY SEAL

Subscribed and sworn to before me this

_____ day of _____,

2_____.

_____
Signature of Notary

Notary Public for State of: _____

My Commission Expires: _____

Residing at: _____
City State

A photocopy of this form will serve as an original.

Please return completed form to:
Nevada State Board of Medical Examiners
PO Box 7238 Reno, Nevada 89510
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

FORM 1

The National Board for Respiratory Care, Inc.
8310 Nieman Road
Lenexa, Kansas 66214
(913) 599 - 4200

Part 1 - *to be completed by applicant*

Printed name of applicant: _____

I am in the process of applying for practitioner of respiratory care licensure in the state of Nevada. I hereby authorize release of the information, requested in Part 2 below, directly to the Nevada State Board of Medical Examiners.

Signature of applicant: _____

Part 2 - *to be completed by The National Board for Respiratory Care, Inc. and RETURNED DIRECTLY TO THE OFFICE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS*

I certify that _____
(name of applicant)
was granted initial certification/registration by The National Board for Respiratory Care, Inc. on:

Date issued: _____

Certificate/Registration Number: _____

The above-referenced certificate/registration is:

_____ Current, in good standing _____ Not current

Expiration date of current certification/registration: _____

Signature and title of certifying individual:

_____ _____
(date)

Completed form is to be returned by The National Board for Respiratory Care, Inc. directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno NV 89510

FORM 2

PRACTITIONER OF RESPIRATORY CARE
EDUCATION VERIFICATION

This certifies that: _____
(printed name of applicant)

DOB:_____ SSN: _____

The following information to be completed by program only.

was enrolled in: _____
(name of practitioner of respiratory care program)

located at: _____
(address of practitioner of respiratory care program)

from: _____ to: _____
(dates of attendance) (dates of attendance)

The applicant successfully completed their respiratory care practitioner training program on

the _____ day of _____, _____.
(date) (month) (year)

Signed and the seal affixed this _____ day of

_____, 2_____.

(affix seal here)

By _____
(typed name and title of President, Dean or Registrar)

_____
(signature of President, Dean or Registrar)

Completed form is to be returned by verifying program directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno NV 89510

FORM 3

PRACTITIONER OF RESPIRATORY CARE
STATE CERTIFICATION/REGISTRATION VERIFICATION

Part 1 - *to be completed by applicant*

Printed name of applicant: ____

Date of birth of applicant: ____

I am applying for practitioner of respiratory care licensure in the state of Nevada. I hereby authorize release of the information, requested in Part 2 below, directly to the Nevada State Board of Medical Examiners.

Signature of applicant: ______________________________________

- -

Part 2 - *to be completed by each state and RETURNED DIRECTLY TO THE OFFICE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS*

I certify that ____
(name of applicant)

was granted certificate/license # ______________________ on ______________________
(date issued)

by the state of ____

on the basis of ____ .
(The National Board for Respiratory Care, Inc. - state examination - other)

The above-referenced certificate/license is:

_______ Current, in good standing _______ Not current, due to non-payment of fees

_______ Other (please attach explanation)

Expiration date of current certificate/license: ___________________________________

I certify that the records in this office indicate that there are not now nor have there ever been any disciplinary action filed against the holder of this certificate/license. (If disciplinary action has been filed, please attach an explanation.)

Signature and title of certifying individual:

____ ______________
(date)

Completed form is to be returned by certifying/licensing state directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno NV 89510